

(DATE)

Dr. \_\_\_\_\_  
(Address)

RE: (Patient's name)

Dear Dr. \_\_\_\_\_,

We have learned that our employee, (patient's name) \_\_\_\_\_, may have a disability. We need your assistance in determining if (patient) \_\_\_\_\_ can perform the essential functions of (his / her) position with or without reasonable accommodation. To help us make a determination on what our options might be, we are asking you to provide the following information concerning (patient)'s condition. I have enclosed a signed medical release and a copy of (patient's) job description. Please return this form to me on or before (date) \_\_\_\_\_.

1. When did you begin treating (patient) \_\_\_\_\_?
2. Did you treat (patient) \_\_\_\_\_ between (date) \_\_\_\_\_ and (date) \_\_\_\_\_?
3. If not, when was the last date you treated (patient) \_\_\_\_\_?
4. Is the condition you are treating (patient) \_\_\_\_\_ for  
\_\_\_\_\_ Physical or physiological disorder or condition  
\_\_\_\_\_ Cosmetic disfigurement  
\_\_\_\_\_ Anatomical loss  
\_\_\_\_\_ Mental or psychological disorder

If any of the above is indicated, briefly describe the nature of the condition and the body systems or mental capacities affected.

6. For each major life activity checked in #5, **describe below** how (patient) is unable to perform the major life activity that the average person in the population can perform; or is significantly restricted as to the condition, manner, or duration under which (patient) can perform a particular major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform the same major life activity.

|       |                         |       |
|-------|-------------------------|-------|
| _____ | Walking                 | _____ |
| _____ | Speaking                | _____ |
| _____ | Breathing               | _____ |
| _____ | Performing manual tasks | _____ |
| _____ | Seeing                  | _____ |
| _____ | Hearing                 | _____ |
| _____ | Learning                | _____ |
| _____ | Caring for oneself      | _____ |
| _____ | Working                 | _____ |

7. What is the expected duration of the disability for (patient)\_\_\_\_\_?

8. What is the permanent or long-term impact, or the expected impact of the disability for (patient)\_\_\_\_\_?

9. Identify any physical restrictions for (patient)\_\_\_\_\_ in any of the areas below that are applicable to (patient's)\_\_\_\_\_ disability.

| <u>Activity</u> | <u>Never</u> | <u>1-3 Hrs/Day</u> | <u>3-5 Hrs/Day</u> | <u>5-8 Hrs/Day</u> |
|-----------------|--------------|--------------------|--------------------|--------------------|
|-----------------|--------------|--------------------|--------------------|--------------------|

|         |          |          |          |          |
|---------|----------|----------|----------|----------|
| Lifting | ___ lbs. | ___ lbs. | ___ Lbs. | ___ Lbs. |
|---------|----------|----------|----------|----------|

|          |          |          |          |          |
|----------|----------|----------|----------|----------|
| Carrying | ___ lbs. | ___ lbs. | ___ Lbs. | ___ Lbs. |
|----------|----------|----------|----------|----------|

| <u>Activity</u> | <u>Never</u> | <u>1-3 Hrs/Day</u> | <u>3-5 Hrs/Day</u> | <u>5-8 Hrs/Day</u> |
|-----------------|--------------|--------------------|--------------------|--------------------|
|-----------------|--------------|--------------------|--------------------|--------------------|

Pushing,  
Pulling

Stooping,  
Twisting or  
Bending

Squatting,  
Crawling or  
Kneeling

Climbing

Reaching

Wrist Use

Hand Use

Sitting

Standing

Walking

Running

Other

Restrictions listed above are in effect until (date)\_\_\_\_\_.

10. If (patient) is substantially limited only in the major life activity of "working", describe the type of jobs from which the individual is disqualified because of the disability.

(patient) is released for regular work / activity. \_\_\_\_\_

(patient) is released with restrictions above. \_\_\_\_\_

11. Describe the accommodation or modifications needed for (patient) (job or activity). (See attached job description.)

Physician's name, address, telephone number and medical specialty:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you have any questions, please call me at (phone number).

Sincerely,

(Name, title)

Enc: Signed Medical Release